

Congress of the United States

Washington, DC 20515

January 25, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

I write regarding actions the Centers for Medicare & Medicaid Services (CMS) should take, using its existing authority, to curb billions in overpayments to private Medicare Advantage (MA) insurers, who now cover over half of all eligible Medicare beneficiaries.¹ I appreciate the important steps CMS has already taken to limit overpayments, such as increasing audit rates of MA insurers² and finalizing necessary adjustments to MA's risk adjustment model.³ Yet, despite your agency's efforts to date, the Committee for a Responsible Federal Budget projects that CMS will overpay MA insurers by as much as \$1.56 trillion over the next decade, while the Physicians for a National Health Program puts the dollar figure at \$1.4 trillion.⁴ As enrollment in MA continues to grow,⁵ CMS must take more aggressive action to ensure Medicare's sustainability, protect taxpayer dollars, and curb abusive practices in MA.

The MA program was founded on the premise that private insurance companies would administer Medicare coverage more cost-effectively, saving taxpayer dollars. However, the MA program has failed to deliver savings in any year since its inception; in fact, the Medicare Payment Advisory Commission (MedPAC) estimates that CMS pays MA plans 6 percent more

¹ Kaiser Family Foundation, "Medicare Advantage in 2023: Enrollment Update and Key Trends," Nancy Ochieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, August 9, 2023, [https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/#:~:text=In%202023%2C%2030.8%20million%20people,spending%20\(net%20of%20premiums\).](https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/#:~:text=In%202023%2C%2030.8%20million%20people,spending%20(net%20of%20premiums).)

² CMS, "CMS Issues Final Rule to Protect Medicare, Strengthen Medicare Advantage, and Hold Insurers Accountable," January 30, 2023, <https://www.cms.gov/newsroom/press-releases/cms-issues-final-rule-protect-medicare-strengthen-medicare-advantage-and-hold-insurers-accountable>.

³ CMS, "Fact Sheet: 2024 Medicare Advantage and Part D Rate Announcement," March 31, 2023, <https://www.cms.gov/newsroom/fact-sheets/fact-sheet-2024-medicare-advantage-and-part-d-rate-announcement#:~:text=The%20Rate%20Announcement%20contains%20detailed,finalized%202024%20risk%20adjustment%20model>.

⁴ Committee for a Responsible Federal Budget, "New Evidence Suggests Even Larger Medicare Advantage Overpayments," July 17, 2023, https://www.crfb.org/blogs/new-evidence-suggests-even-larger-medicare-advantage-overpayments#:~:text=Using%20MedPAC's%20coding%20intensity%20estimate,of%20higher%20Part%20B%20premiums;PhysiciansForaNationalHealthProgram,OurPaymentsTheirProfits,October4,2023,https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf..

⁵ Axios, "Medicare Advantage's growth spurt brings tensions," Maya Goldman, October 16, 2023, <https://www.axios.com/2023/10/16/medicare-advantage-enrollment-growth>.

per enrollee than what it would cost to cover the same enrollee in Traditional Medicare (TM),⁶ even though MA plans spend up to 25 percent less on health care per enrollee.⁷ Indeed, as Health and Human Services (HHS) Secretary Xavier Becerra noted, there is “evidence that in certain areas there seems to be [MA] charges that go beyond what would be necessary.”⁸ The combination of overpayments and aggressive denials of care has allowed private MA insurers to more than double their profit margins compared to other health insurance markets.⁹

As a result of these factors, the MA program has jeopardized the solvency of Medicare’s Hospital Insurance Trust Fund,¹⁰ raised Part B premiums for *all* Medicare beneficiaries by as much as \$140 billion over ten years,¹¹ and created significant barriers to care for vulnerable enrollees.¹² It is imperative for CMS to rein in these abuses and protect Medicare coverage for the seniors and people with disabilities who rely on it. As CMS prepares the CY25 Advance Notice of MA Payment Policies, I respectfully urge you to pursue the following actions:

Reform base payments to offset favorable selection

Each month, CMS sends MA plans a capitated payment based on how much the agency estimates it will cost to provide care for one MA beneficiary. One part of that capitated payment is the base payment, which is calculated by taking the average spending of a beneficiary in TM in the MA plan’s local county. However, this comparison, known as the “benchmark,” overlooks that MA enrollees tend to be younger and healthier than TM enrollees, meaning their care costs far less.¹³ As a result, because the current benchmark system fails to fully take this discrepancy, or “favorable selection,” into account, MA insurers receive inflated medical payments from CMS, pay out fewer claims, and then pocket the rest, leading to gross overpayments. According

⁶ Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2023, p. 13, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf.

⁷ The American Prospect, “Medicare Advantage Is a Massive Scam,” Ryan Cooper, April 29, 2022, <https://prospect.org/health/medicare-advantage-is-a-massive-scam/>.

⁸ Fierce Health Care, “Becerra: HHS wants to get 'money's worth' on Medicare Advantage, will look into coding practices,” March 18, 2022, <https://www.fiercehealthcare.com/payers/becerra-hhs-wants-get-moneys-worth-medicare-advantage-will-look-coding-practices#:~:text=practices%20%7C%20Fierce%20Healthcare-.Becerra%3A%20HHS%20wants%20to%20get%20'money's%20worth'%20on%20Medicare,will%20look%20into%20coding%20practices&text=The%20Department%20of%20Health%20and,Xavier%20Becerra%20told%20reporters%20Friday.>

⁹ Kaiser Family Foundation, “Medicare Advantage Insurers Report Much Higher Gross Margins Per Enrollee Than Insurers in Other Markets,” Craig Palosky, February 28, 2023, <https://www.kff.org/medicare/press-release/medicare-advantage-insurers-report-much-higher-gross-margins-per-enrollee-than-insurers-in-other-markets/>.

¹⁰ Committee for a Responsible Federal Budget, “New Evidence Suggests Even Larger Medicare Advantage Overpayments,” July 17, 2023, <https://www.crfb.org/blogs/new-evidence-suggests-even-larger-medicare-advantage-overpayments#:~:text=Using%20MedPAC's%20coding%20intensity%20estimate,of%20higher%20Part%20B%20p%20remiums.>

¹¹ *Id.*; Letter from Senator Elizabeth Warren to HHS Secretary Becerra and CMS Administrator Brooks-LaSure, March 27, 2023, <https://www.warren.senate.gov/imo/media/doc/2023.03.27%20Letter%20to%20CMS%20re%20Medicare%20Advantage%20and%20Part%20B%20Premiums.pdf>.

¹² The New York Times, “Medicare Advantage Plans Often Deny Needed Care, Federal Report Finds,” Reed Abelson, <https://www.nytimes.com/2022/04/28/health/medicare-advantage-plans-report.html>.

¹³ The American Prospect, “Medicare Advantage Is a Massive Scam,” Ryan Cooper, April 29, 2022, <https://prospect.org/health/medicare-advantage-is-a-massive-scam/>.

to the USC Schaeffer Center, favorable selection cost taxpayers \$40.9 billion in 2020 alone, while MedPAC estimates that favorable selection will inflate MA payments by \$36 billion in 2024.¹⁴

To limit overpayments attributable to favorable selection, CMS should:

- 1. Modify benchmarks to offset favorable selection:** When setting benchmarks, CMS uses a geographic adjustment to calculate historical TM spending at the county-level. MA plans' benchmarks are then adjusted based on whether average TM spending in that county is higher or lower than the TM national average, which can lead to significant changes in the maximum payments MA plans may receive from CMS.¹⁵ As total enrollment in TM decreases, especially among healthy seniors, the current geographic adjustment will continue to factor higher local TM spending into MA benchmarks, leading to even higher overpayments from favorable selection. This overpayment from favorable selection is greater in areas with more MA penetration.¹⁶ CMS should therefore alter benchmark calculations to account for county-level MA penetration rates, such as by introducing a new "favorable selection factor."¹⁷
- 2. Modify calculation of United States Annual Per Capita Costs (USPCC) to account for favorable selection.** CMS has considerable discretion in the methods it uses to calculate annual per capita costs in TM, which are used to set capitation rates in MA. CMS may be able to modify the calculation of the USPCC to account for differences in health status between MA and TM that contribute to favorable selection.

Risk adjustment

In addition to the base payment, MA insurers' capitated rates are further adjusted based on their enrollees' risk scores. Risk scores are intended to measure how sick enrollees are – and by extension, how much health care they might consume. Plans can receive higher payments for patients with higher risk scores, which is intended to prevent plans from choosing not to cover sicker patients. But it also gives plans an incentive to make enrollees appear sicker than they really are in an effort to boost their profits.¹⁸

¹⁴ USC Schaeffer, "Favorable Selection Ups the Ante on Medicare Advantage Payment Reform," Steve Liberman and Paul Ginsburg, June 13, 2023, <https://healthpolicy.usc.edu/article/favorable-selection-ups-the-ante-on-medicare-advantage-payment-reform/>; MedPAC, "The Medicare Advantage program: Status report," Stuart Hammond, Andy Johnson, and Luis Serna, January 12, 2024, <https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf>.

¹⁵ Journal of Health Politics, Policy, and Law, "Legislative and Regulatory Options for Improving Medicare Advantage," Erin Fuse Brown, Travis Williams, Roslyn Murray, David Meyers, Andrew Ryan, December 1, 2023, p. 924-934, <https://read.dukeupress.edu/jhpl/article/48/6/919/379609/Legislative-and-Regulatory-Options-for-Improving>.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ STAT, "Upcoding: one reason Medicare Advantage companies pay clinicians to make home health checkups," Robert Kaplan and Paul Tang, <https://www.statnews.com/2023/01/19/rein-in-upcoding-medicare-advantage-companies/>.

Indeed, there is extensive evidence that plans aggressively inflate enrollee risk scores through “upcoding,” in which MA plans seek to add as many diagnosis codes as possible to their enrollees’ medical charts.¹⁹ Many MA insurers exploit this loophole through the use of health risk assessments (HRAs), sending nurses or other health professionals to patients’ homes with the intention of collecting diagnostic codes. Others employ chart review companies – which are sometimes owned by MA insurers²⁰ – to add diagnosis codes based on reviews of patients’ medical records. For example, UnitedHealthcare – the largest MA insurer – used HRAs and chart reviews to squeeze taxpayers out of \$3.7 billion in 2017,²¹ while four of the five largest MA insurers have been sued in federal court for upcoding. Recent evidence from MedPAC suggests that upcoding will cost taxpayers \$54 billion in 2024 alone.²²

While the risk adjustment model desperately needs broader reforms, including reassessing the values of hierarchical condition categories (HCC) codes, CMS should take more pointed action to limit overpayments attributable to upcoding, including:

- 1. Increasing the coding intensity adjustment factor:** Congress has directed CMS to apply a minimum 5.9 percent coding pattern adjustment, or reduction, each year to account for the differences in coding patterns between MA and TM.²³ Despite mounting evidence of upcoding, including the fact that the average risk score in MA was 20 percent higher than in TM in 2019,²⁴ CMS has never increased the adjustment above 5.9 percent. CMS should increase the coding adjustment factor upward as necessary and could consider adopting a variable coding intensity adjustment factor based on the specific coding and audit experiences of MA contracts to account for differences among plans. CMS should also publish its annual analysis of coding intensity each year.
- 2. Increase recoupment of overpayments:** In 2018, CMS proposed a rule to apply the agency’s risk adjustment data validation (RADV) audits – which review medical records to identify unsupported diagnosis codes – to MA plans dating back to 2011. However, when CMS finalized the rule in 2023,²⁵ the agency announced that the RADV audits would only evaluate claims beginning in 2018.²⁶ This allows MA insurers to avoid accountability for seven years of overpayments without penalty at a cost to taxpayers of

¹⁹ Physicians For a National Health Program, “Our Payments Their Profits,” October 4, 2023, https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf.

²⁰ HealthcareDive, “CVS closes \$8B Signify acquisition,” Rebecca Pifer, March 27, 2023, <https://www.healthcaredive.com/news/cvs-close-signify-acquisition/646018/>.

²¹ Fierce Healthcare, “OIG: UnitedHealthcare banked \$3.7B in Medicare Advantage payments in 2017 through chart reviews, HRAs,” Paige Minemyer, October 21, 2021, <https://www.fiercehealthcare.com/payer/oig-unitedhealthcare-banked-3-7b-medicare-advantage-payments-2017-through-chart-reviews-hras>

²² MedPAC, “The Medicare Advantage program: Status report,” Stuart Hammond, Andy Johnson, and Luis Serna, January 12, 2024, <https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf>.

²³ Committee for a Responsible Federal Budget, “Reducing Medicare Advantage Overpayments,” February 23, 2021, <https://www.crfb.org/papers/reducing-medicare-advantage-overpayments>.

²⁴ Physicians For a National Health Program, “Our Payments Their Profits,” October 4, 2023, https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf.

²⁵ Fierce Healthcare, “Medicare Advantage plans lose out in final RADV audit rule that ditches fee-for-service adjuster,” Robert King, January 30, 2023, <https://www.fiercehealthcare.com/payers/medicare-advantage-plans-lose-out-final-radv-audit-rule-ditches-fee-service-adjuster>.

²⁶ *Id.*

about \$2 to \$3 billion.²⁷ If CMS cannot reverse this decision, CMS should increase recoupments by more robustly enforcing the 2014 Overpayment Rule, which requires MA plans to identify clinically unsupported diagnosis codes and return overpayments to CMS within 60 days.²⁸ While MA insurers have fought this rule tooth and nail, the courts have confirmed CMS's authority to penalize MA insurers that willfully disregard overpayments using the Overpayment Rule.²⁹ Further, CMS should withhold or offset MA insurers' current payments to recoup overpayments,³⁰ allocate more agency resources to RADV audits, and put time limits on the protracted RADV appeals process.

- 3. Restrict the use of chart reviews and health risk assessments (HRAs):** According to the HHS Office of the Inspector General (OIG), HRAs and chart reviews are “a major driver of improper payments in the MA program.”³¹ HHS OIG found that over 99 percent of chart reviews analyzed resulted in added diagnosis codes.³² Similarly, MedPAC has recommended that CMS disregard codes that have been generated from chart reviews. CMS should implement MedPAC's recommendation and consider further disregarding or capping codes derived from HRAs only.
- 4. Eliminate the use of provider incentives that contribute to increased coding:** MA plans are increasingly employing reimbursement programs, including value-based contracts, to reward providers for aggressively upcoding.³³ CMS should prohibit these payment arrangements and further require MA plans to report the Medical Loss Ratio (MLR) for related entities that operate under risk contracts with the parent, as these trends are more pronounced for MA insurers who own the providers with whom they enter into such contracts.³⁴ Profits from related entities that revert to the parent should also be excluded from medical expenses when the related insured entity submits its MLRs to CMS.

²⁷ Journal of Health Politics, Policy, and Law, “Legislative and Regulatory Options for Improving Medicare Advantage,” Erin Fuse Brown, Travis Williams, Roslyn Murray, David Meyers, Andrew Ryan, December 1, 2023, p. 935, <https://read.dukeupress.edu/jhpl/article/48/6/919/379609/Legislative-and-Regulatory-Options-for-Improving>.

²⁸ *Id.*

²⁹ *Id.* p. 936.

³⁰ Health Affairs, “Medicare Advantage Audit Changes Let Plans Keep Billions In Overpayments,” Travis Williams, Erin Fuse Brown, David Meyers, Roslyn Murray, Andrew Ryan, February 27, 2023, <https://www.healthaffairs.org/content/forefront/medicare-advantage-audit-changes-let-plans-keep-billions-overpayments>.

³¹ HHS OIG, “Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments,” September 2021, <https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf>; NIH, “Medicare Advantage Chart Reviews Are Associated with Billions in Additional Payments for Some Plans,” David Meyers and Amal Trivedi, February 1, 2022, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7855237/>.

³² *Id.*

³³ Health Affairs, “Medicare Advantage, Direct Contracting, And The Medicare ‘Money Machine,’ Part 1: The Risk-Score Game,” Richard Gilfillan and Donald Berwick, September 29, 2021, <https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game>; JAMA Network, “Comparison of Care Quality Metrics in 2-Sided Risk Medicare Advantage vs Fee-for-Service Medicare Programs,” Kenneth Cohen, Omid Ameli, Christine Chaisson, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799376>.

³⁴ The Motley Fool, “UnitedHealth Group (UNH) Q1 2021 Earnings Call Transcript,” April 15, 2021, <https://www.fool.com/earnings/call-transcripts/2021/04/15/unitedhealth-group-unh-q1-2021-earnings-call-trans/>.

Reform the Quality Bonus Program

On top of overpayments from favorable selection and upcoding, CMS also sends quality bonus payments (QBPs) to MA plans that have been awarded four or five stars through the agency's star ratings system. Plans that meet certain quality metrics, such as clinical processes and health plan performance, can receive bonus payments that are 5 to 10 percent of the local county's benchmark.³⁵ However, while most MA plans receive quality bonus payments, there is no evidence that quality bonus payments actually improve plan quality.³⁶ And because of gaps in CMS's data collection in the MA program – such as critical information on prior authorization denials³⁷ – these quality measurements are highly flawed. Moreover, because these questionable star ratings are applied at the contract-level, rather than the plan-level, insurers often consolidate their plans to artificially inflate their star rating.³⁸ According to MedPAC, CMS sends \$15 billion to MA insurers in quality bonus payments each year.

- 1. Raise the standard for QBP:** Currently, 85 percent of MA plans are eligible for quality bonus payments, and plans that do not qualify face no economic penalties.³⁹ In addition to improving data collection practices to more accurately track plan performance, which I have already urged you to do,⁴⁰ CMS should raise the standards required to achieve 4 or more stars; improve quality metrics by focusing on more impactful measurements such as prior authorization and payment denials; and award star ratings at the plan-level instead of the contract-level.
- 2. Apply a network quality measure to MA plans' star rating:** MA enrollees often use lower rated hospitals, Skilled Nursing Facilities, and Home Health providers, than TM

³⁵ Keiser Family Foundation, "Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023," Jeannie Fuglesten Biniek, Anthony Diamico, and Tricia Neuman, August 9, 2023, <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-payments-will-reach-at-least-12-8-billion-in-2023/>.

³⁶ NIH, "The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality," Adam Markovitz, John Ayanian, Devraj Sukul, Andrew Ryan, December 1, 2021,

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9098184/>; NIH, "Medicare Advantage Chart Reviews Are Associated with Billions in Additional Payments for Some Plans," David Meyers and Amal Trivedi, February 1, 2022, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7855237/>.

³⁷ Health Payer Intelligence, "Medicare Advantage Quality Bonus Program Needs Reform, Report Find," Victoria Bailey, July 11, 2023, <https://healthpayerintelligence.com/news/medicare-advantage-quality-bonus-program-needs-reform-report-finds#:~:text=July%2011%2C%202023%20%2D%20The%20Medicare,performance%20across%20Medicare%20Advantage%20contracts.>

³⁸ MedPAC, "June Report to Congress Chapter 3: Replacing the Medicare Advantage quality bonus program," p. 52, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf.

³⁹ Keiser Family Foundation, "Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023," Jeannie Fuglesten Biniek, Anthony Diamico, and Tricia Neuman, August 9, 2023, <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-payments-will-reach-at-least-12-8-billion-in-2023/>.

⁴⁰ Letter from Senator Elizabeth Warren to CMS Administrator Brooks-LaSure, December 7, 2023, <https://www.warren.senate.gov/imo/media/doc/2023.12.07%20Letter%20to%20Admin.%20Brooks-LaSure%20re%20MA%20Data.pdf>

enrollees.⁴¹ MA enrollees also receive lower quality cancer services and experience higher mortality rates for complex cancer procedures.⁴² However, quality measures that determine a plan's star rating, and later the insurer's bonus payments, do not include network quality.⁴³ CMS should therefore create a network quality score for every MA Plan and include it in the star ratings. The measure should include a score that captures the relative proportion of care provided by five-, four-, three-, and two-star providers and comprehensive cancer centers and university hospitals as compared to the proportion used by the TM population in the same region.

Strengthen enforcement against MA insurers that illegally deny care

Through favorable selection, upcoding, and QBPs, MA insurers receive as much as \$104 billion in overpayments per year. Yet, with all this extra cash, MA insurers still regularly deny medically necessary care to MA enrollees, even though federal law requires them to cover all Medicare Part A and Part B services. For example, a 2019 HHS OIG investigation found that among all requests MA plans denied, 13 percent of prior authorization denials and 18 percent of payment denials met Medicare coverage rules, meaning the MA plans unlawfully delayed or denied enrollees access to services that would have been approved under TM.⁴⁴

With few guardrails against abuse, these trends have only worsened. From 2020 to 2022, appeals of MA denials increased by nearly 58 percent, thanks in part to greater use of artificial intelligence (AI) to systematically deny care, conservatively saving insurers hundreds of millions of dollars.⁴⁵ These denials have become so pervasive in MA that hospital systems in at least 11 states have either severely restricted or severed ties with MA insurers, citing burdensome prior authorization claims, retroactive payment denials, and billing fraud.⁴⁶ Meanwhile, patients fed up with denials are following suit: a 2022 MedPAC study found that seniors in MA who need more

⁴¹ Keiser Family Foundation, "Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature," Nancy Ochieng and Jeannie Fuglesten Biniek, <https://www.kff.org/medicare/report/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/#:~:text=Quality%20of%20facility%20or%20provider,traditional%20Medicare%20beneficiaries%20to%20receive.>

⁴² *Id.*; Cure, "When It Comes to Cancer Care, Not All Medicare Plans Are The Same," Harlan Levine, November 7, 2023, <https://www.curetoday.com/view/when-it-comes-to-cancer-care-not-all-medicare-plans-are-the-same>.

⁴³ The Urban Institute, "The Medicare Advantage Quality Bonus Program," Laura Skopec and Robert Berenson, June 2023, p. 10, <https://www.urban.org/sites/default/files/2023-06/The%20Medicare%20Advantage%20Quality%20Bonus%20Program.pdf>.

⁴⁴ HHS OIG, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," April 27, 2022, <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp>.

⁴⁵ STAT, "Denied by AI: How Medicare Advantage plans use algorithm to cut off care for seniors in need," Casey Ross and Bob Herman, March 13, 2023, <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/>; STAT, "UnitedHealth used secret rules to restrict rehab care for seriously ill Medicare Advantage patients," Bob Herman and Casey Ross, <https://www.statnews.com/2023/12/28/medicare-advantage-united-health-navihealth-rehab-care-restrictions/>.

⁴⁶ Beckers Hospital Review, "Hospitals are dropping Medicare Advantage Plans left and right", Jakob Emerson, December 14th, 2023, <https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html>

health care are more likely than healthier seniors to disenroll from MA,⁴⁷ and the Government Accountability Office reported that enrollees in MA plans are more than twice as likely as other enrollees to switch to TM during their last year of life.⁴⁸

In other words, when seniors enrolled in MA get sick and need more health care services, they are often forced to switch to TM because their private health insurers – who are required by law to provide all Medicare Part A and Part B services – make it nearly impossible to access necessary care. To limit unnecessary payment and care denials and hold bad actors accountable, CMS should:

- 1. Investigate abuse of AI models:** Reports indicate that, when asked to explain payment and care denials, MA insurers regularly claim that their AI programs are “proprietary,”⁴⁹ making it exceedingly difficult for patients and doctors to verify if the plans’ decisions are violating Medicare coverage rules. Moreover, CMS currently does not regulate the algorithms for accuracy.⁵⁰ CMS should audit insurers’ AI models to ensure their recommendations meet Medicare coverage rules;⁵¹ investigate whether the models are trained on populations that reflect the demographics of MA enrollees; and determine whether AI models learn from past erroneous determinations.⁵² CMS should prohibit the use of such models until the agency can verify that insurers have met these requirements.
- 2. Terminate contracts that are in violation of Medicare coverage rules:** Under the Medicare statute, CMS can terminate contracts with MA organizations if the entity no longer meets CMS coverage requirements.⁵³ CMS has used this authority to terminate contracts with low star ratings,⁵⁴ and should also use it to terminate contracts when plans are found to be routinely denying medically necessary care.

⁴⁷ MedPAC, “The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans, p. 432, March 2022, https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf; JAMA, “Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries,” David Meyers, Emmanuelle Belanger, Nina Joyce, Hohn McHugh, Momotazur Rahman, Vincent Mor, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6450306/>.

⁴⁸ GAO, Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending,” June 28, 2021, <https://www.gao.gov/products/gao-21-482>.

⁴⁹ STAT, “Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need,” Casey Ross and Bob Herman, March 13, 2023, <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/>.

⁵⁰ STAT, “Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need,” Casey Ross and Bob Herman, March 13, 2023, <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/>.

⁵¹ KFF, “Feds Rein In Use of Predictive Software That Limits Care for Medicare Advantage Patients,” Susan Jaffe, October 5, 2023, <https://kffhealthnews.org/news/article/biden-administration-software-algorithms-medicare-advantage/>.

⁵² Representative Chu letter to CMS Administrator Brooks-LaSure, November 3, 2023, <https://chu.house.gov/sites/evo-subsites/chu.house.gov/files/evo-media-document/chu-nadler-ma-ai-oversight-letter-11.3.2023.pdf>.

⁵³ 42 CFR § 422.510

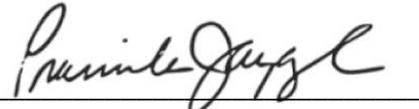
⁵⁴ Becker’s Payer Issues, “4 Medicare Advantage contracts recently terminated by CMS,” Jakob Emerson, January 10, 2023, <https://www.beckerspayer.com/contracting/4-medicare-advantage-contracts-recently-terminated-by-cms.html>

To protect Medicare beneficiaries and curb billions in overpayments driven by for-profit insurers, I respectfully urge you to take the actions outlined in this letter. Doing so will save hundreds of billions of taxpayer dollars, ensure Medicare's sustainability, and improve health outcomes for Medicare enrollees. I also request that you provide a staff-level briefing on CMS's plan to limit overpayments and hold MA insurers accountable for widespread delays and denials by February 8, 2024.

Sincerely,



Elizabeth Warren
United States Senator



Pramila Jayapal
United States Senator